ing of this bone and lipping of the joint cartilage with subsequent pain through the plantar area. By cramp of the flexor brevis, hallux malleus is developed. This condition strips the abductor hallucis of its power. When the adductors prevail hallux-malleo-valgus frequently evolves, noted by the callosity on the plantar side of the interjoint of the big toe. Luxation of the extensor proprius and flexor longus hallucis is needed for hallux valgus in most cases the acknowledged effect of too narrow or too pointed shoes, especially when high heels are worn with them. From the above it follows that well fitting shoes and raising of the inner border may largely contribute toward preventing the development of these conditions. Treatment should be directed both to muscle balance and joint wear. Transplantation of abductor hallucis has proved useful to the author. In quite severe cases it may be combined with shortening of the first metatarsal according to Ludloff's method or by removal of part of the metatarsal neck.

An Integral Traction-providing Splint for Vicious Fractures of the Femur.—MASLAND (*Ann. of Surg.*, 1921, lxxiii, 495) says that all the various modifications of the Thomas and Hodgen splints are equipped with pelvic rings which give a one point support to the ischium. This permits of but limited amount of pressure without pain. The author's splint utilizes all opportunities offered by the body to distribute the strain and so allow greater traction with less discomfort. The joints above and below the fracture are immobile; the individual fit of the splints insures their better retention in position. The body and the fractured part are open for inspection and the needful attention. The strain of traction is distributed in wider degree over salient parts of the body while traction can be applied in the direction and to the degree required for traction is wholly integral to the splint. The patient can move or be moved on the bed without disturbing the direction of traction or the relation of the parts. Comfort and well-being are conserved in the highest degree.

Drainage of Common Duct through Cystic Duct: Cystico-choledochostomy.—REID (*Ann. of Surg.*, 1921, lxxiii, 458) says that Halstead advocated careful and complete closure of incision into the choledochus and drainage of this duct by a tube passed well into it by way of the ductus cysticus as early as 1897. Halstead and the author have done much work upon dogs in this problem and are now doing the operation routinely in the Johns Hopkins Hospital. Their technic is described and cases cited. The procedure offers several advantages, for the incision into the common bile duct may be closed completely and with union by first intention, while emaciation and weakness due to loss of bile for protracted periods is avoided. Healing of the abdominal wound and drainage tract is less likely to be delayed, because leakage of bile is avoided. The patency of the duct may be tested routinely by clamping the tube. Finally on removal of the tube there has been no leakage in more than one-half the cases.

A Perineal Operation for Removal of Stone in Lower End of the Male Ureter.—LOWSLEY (*Surg., Gynec. and Obst.*, 1921, xxxii, 300) says that a careful review of the anatomy of the male pelvis with careful dissection on the cadaver impressed upon him the accessibility of the lower

end of the ureter by means of the perineal route. He describes the developed technic for removal of stone by this route. The perineal route should only be attempted when the stone is less than 4 cm. from the bladder and fixed in position. The patient may be allowed out of bed after the second day and the downhill drainage would seem to be a decided advantage in that the chances of thick scar formation around the ureter are less. Moreover, this downhill drainage prevents absorption of urine and deleterious results from concomitant infection which frequently accompanies urinary lithiasis. Finally chances of wide infection of tissues around incision in ureter and subsequent stricture of ureter are much less.

Resection of Intestine for Acute Intussusception: Two Cases of Recovery.—SOUTHAM and CRAWSHAW (*British Med. Jour.*, February 19, 1921, p. 266) say that the published results show that the mortality of enterectomy in cases of acute intussusception is extremely high. In an earlier collection of 239 cases by Gibson, there was no recovery from irreducible intussusception in a patient under seven years. Barker says that he had never seen a recovery after resection in a gangrenous state and never expected to see it. The 2 reported cases were three years and six months old respectively. In both cases the intestine was gangrenous. Extensive resection was necessary but complete and uneventful recoveries followed. The successful issue was due to measures taken to safeguard the patient from the effects of shock. *Speed* in operating is essential. Everything should be ready to hand while closure of the laparotomy should be carried out by through-and-through sutures. *Body heat* should be preserved by bandaging the child in a suit of gamgee and the theater maintained as warm as possible. The anesthetic appears closely related to the amount of shock present. This was minimized by using gas and oxygen in 1 case while no anesthetic was used in the other. Shock further depends upon water starvation, resulting from the previous vomiting and loss of fluid. In both the reported cases, postanesthetic vomiting was entirely absent. Fluids were given and retained immediately after the completion of the operations.

On the End-results of Colectomies for Intestinal Stasis.—SHEEN (*British Med. Jour.*, December 22, 1921, p. 116) reports the end results of 4 complete colectomies performed in 1913–14. One of them died soon after operation. In the other three there was great improvement; in two, what might be termed complete success. The qualifying details are: in the first case a ventral hernia with dyspeptic symptoms; in the second, adhesions fortunately not interfering with pregnancy; in the third diarrhea occasionally. There is an operative parietal infection in these and similar cases which it is justifiable to regard as coming from within. Possibly the poorly vitalized parietes cannot deal with organisms which the peritoneal cavity can put up with, in these toxic subjects. The usual germ is B. coli. In spite of the good results in these 3 cases, the author confesses that he is not enamoured of this operation. He accepts the toxemia, its signs and symptoms—that it is due to a blocking of the ileal effluent owing to displacements, kinks and adhesions of cecum and colon, these again resulting from upright posture, habitual constipation and tight clothing in women. The surgical "purists" say that there are only two lines of treatment, paraffin